OMB Approved No. 2900-0068
Respondent Burden: 40 Minutes

Department of Veterans Affairs

APPLICATION FOR SERVICE-DISABLED INSURANCE

You may qualify for up to $10,000 coverage at regular premium rates even if you have been rejected for insurance by a commercial company or were offered a policy at high premiums because of a disability.

Before you decide to apply for this coverage we encourage you to be a smart shopper and compare our premium rates to a few other insurance companies. After all, life insurance is an important decision and we want you to get the best deal possible for your money. If your disability is not serious, a commercial company may be able to offer you a better deal. Compare their premium rates to the Government Life Insurance rates in VA Pamphlet 29-9.

When considering the cost of this coverage, remember that if you become totally disabled and unable to work for six or more months, you do not have to pay premiums on your Government Life Insurance policy. This benefit is added at no extra cost. Most commercial life insurance companies add an additional charge for this benefit.

Do not delay when comparing costs; you have only two years from the date VA notified you of your service-connected disability to apply for our coverage (this time period is reduced to one year if the date VA notified you of your service-connected disability was prior to September 1, 1991). (NOTE: Although not required, if you send in a copy of your disability notification letter, it may help us process your application more quickly.

If you have any questions on Government Life Insurance, just call our toll-free number, 1-800-669-8477. We will be on the line ready to help you with your questions. If you decide to apply, fill out the application below.

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS APPLICATION

1. NAME AND MAILING ADDRESS FOR INSURANCE PURPOSES

FIRST, MIDDLE, LAST NAME

NUMBER AND STREET OR RURAL ROUTE

CITY, STATE AND ZIP CODE

2. BENEFICIARY DESIGNATION AND SELECTION OF OPTIONAL SETTLEMENT

COMPLETE NAME AND ADDRESS OF EACH PRINCIPAL AND CONTINGENT BENEFICIARY *(If a married woman, enter her own first and middle names. For example, Mary Rose Smith, not Mrs. John Smith).*	BENEFICIARY'S SOCIAL SECURITY NO. *(If known, See Important Information on reverse)*	RELATIONSHIP OF EACH TO THE INSURED	AMOUNT TO EACH *(Fractions such as 1/2, 2/3, or 3/4)*	OPTION FOR EACH *(1,2,3 OR 4)*
				1
				1
OR TO SURVIVORS				1
CONTINGENT *(Person/s who get the proceeds if the principal beneficiary/ies die before the insured. If none, write "NONE".)*				
				1
				1
OR TO SURVIVORS				1

DO NOT WRITE IN THE SPACE BELOW - FOR VA USE ONLY

ENTER BY VA	SIGNATURE OF VA INSURANCE OFFICIAL	DATE RECORDED

Continued on Reverse

EVERY QUESTION MUST BE ANSWERED, BE SURE TO SIGN ON THIS SIDE

3. VA CLAIM NUMBER *(If any)*	4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH *(Month, Day, Year)*	6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

7. ENTER AMOUNT, PLAN AND PREMIUM OF THE INSURANCE FOR WHICH YOU ARE APPLYING

A. AMOUNT OF INSURANCE	B. PLAN OF INSURANCE	C. MONTHLY PREMIUM

8. CHECK THE METHOD SHOWING HOW YOU WISH TO PAY FOR THIS INSURANCE

☐ A. I WANT TO PAY PREMIUMS BY A MONTHLY DEDUCTION FROM MY VA COMPENSATION OR PENSION
(We will start the deduction for you if the insurance is approved)

☐ B. I WANT TO PAY PREMIUMS BY A MONTHLY ALLOTMENT FROM MY MILITARY SERVICE/RETIREMENT PAY
(We will start the allotment for you if the insurance is approved)

☐ C. I WANT VA TO AUTOMATICALLY WITHDRAW THE PREMIUM EACH MONTH FROM MY BANK ACCOUNT (VA MATIC)
(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION-We will contact you for additional information needed to start the withdrawal)

☐ D. I WILL SEND PREMIUMS DIRECTLY TO VA AS FOLLOWS:
(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION)

☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

9A. ARE YOU NOW WORKING	9B. DO YOU WORK FULL-TIME? ☐ YES ☐ NO	9C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

10A. ARE YOU NOW HOSPITALIZED? ☐ YES ☐ NO *(If "YES", for what condition(s)?*	10B. NAME AND ADDRESS OF HOSPITAL

11. HAVE YOU AT ANY TIME REQUIRED ANY FORM OF TREATMENT OR REHABILITATION OR BEEN FORCED TO DISCONTINUE EMPLOYMENT AS A RESULT OF THE USE OF ALCOHOL OR DRUGS, INCLUDING MARIJUANA, SEDATIVES, STIMULANTS, BARBITURATES, ETC.?
☐ YES ☐ NO *(If "YES", give dates(s) and type of treatment(s)*

12. HAVE YOU HAD ANY OF THE FOLLOWING:	YES	NO
A. DIZZY OR FAINTING SPELLS?	☐	☐
B. TUBERCULOSIS, BRONCHITIS, OR PLEURISY?	☐	☐
C. MENTAL OR NERVOUS DISORDERS?	☐	☐
D. BLOOD DISORDER?	☐	☐
E. HEART CONDITION?	☐	☐
F. CANCER, TUMOR, OR GOITER?	☐	☐
G. ULCERS OR GALLSTONES?	☐	☐
H. DIABETES?	☐	☐
I. EPILEPSY OR PARALYSIS?	☐	☐
J. HIGH BLOOD PRESSURE?	☐	☐

13. IF YOUR ANSWER TO ANY PART OF ITEM 12 IS "YES" GIVE DATES, DURATION, AND OTHER DETAILS
(If more space is needed, attach a separate sheet)

14. HAVE OU HAD ANY OTHER PHYSICAL DEFECT OR DISEASE?
☐ YES ☐ NO *(IF "YES", explain)*

15A. HEIGHT FEET INCHES	15C. HAS YOUR WEIGHT CHANGED MORE THAN 10 POUNDS DURING THE PAST TWO YEARS? *(If "YES", give complete details including amount gained or lost and length of time present weight maintained)* ☐ YES ☐ NO
15B. WEIGHT LBS.	

CERTIFICATION: I have reviewed all of my answers above and certify that they are true and correct to the best of my knowledge and belief.

16A. SIGNATURE OF APPLICANT *(Do not print; sign in ink)*	16B. DATE

IMPORTANT INFORMATION

This form may be used by any person released from active service in the Armed Forces on or after April 25, 1951, who has a service-connected disability and meets good health standards as established by the Secretary. The application for insurance and payment of the required premium must be nade within two years from the date of notice by the Department of Veterans Affairs (VA) that any disabilities are determined to be service-connected (this time period is reduced to one year if the date VA notified you of your service-connected disability was prior to September 1, 1991). Only the veteran, or COURT-APPOINTED guardian, or VA recognized fiduciary, can apply for this insurance. DO NOT DELAY SENDING THIS DESIGNATION if you do not have a beneficiary's Social Security number handy. Your application and designation are still valid even if you do not know the Social Security number, so send this form promptly upon completion. Having the beneficiary's Social Security number will help us locate the beneficiary.

After completion of this application, submit it IMMEDIATELY to:

DEPARTMENT OF VETERANS AFFAIRS
REGIONAL OFFICE AND INSURANCE CENTER (RH)
P. O. BOX 7208
PHILADELPHIA, PA 19101

IF YOU HAVE ANY QUESTIONS ABOUT THIS INSURANCE, PLEASE CALL TOLL-FREE AT 1-800-669-8477.

*U.S. Government Printing office: 1996 - 716 - 890/83293